



Colorado Medicaid Benefit Coverage Standard

BARIATRIC SURGERY

Brief Coverage Statement

Colorado Medicaid covers bariatric surgery for the treatment of clinically severe obesity, when medically necessary as described in this policy.

Bariatric surgery is preferably performed under the guidance of a multidisciplinary team (including surgeon, physician, dietician, and licensed qualified mental health professional) particularly experienced in the performance of bariatric surgery and the pre- and post-operative management of bariatric surgery.

Colorado Medicaid is committed to risk-appropriate care that will enhance optimal health and well being. Best practice guidelines include establishing a healthy lifestyle incorporating regular exercise, as well as a diet high in fruits and vegetables and low in both saturated fats and sugars. Bariatric surgery plays a role in managing severely obese clients who are unable to achieve appropriate body weight by diet and exercise alone, especially in situations of clinically severe obesity with medical co-morbidities.

Colorado Medicaid does not distinguish between criteria for adults and teenagers, except that the mental health evaluations for teenagers must also address issues specific to the teenagers' maturity as relates to compliance with postoperative instructions.

Services Addressed in Other Benefit Coverage Standards

- None

Eligible Providers

1. All providers must be enrolled with Colorado Medicaid.
2. Surgery by surgeons trained and credentialed in bariatric surgery procedures
3. Preoperative evaluations and treatment by:
 - 3.1. Primary care physician,
 - 3.2. Nurse Practitioner,
 - 3.3. Physician Assistant,
 - 3.4. Registered dietician,
 - 3.5. Mental health providers available through the client's Behavioral Health Organization.



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Eligible Place of Service

1. Surgery – Hospital: Facilities must have safety protocols in place specific to the care and treatment of bariatric clients, or meet or be progressing toward compliance with minimum facility standards for bariatric surgery, as established by the Centers for Medicare and Medicaid Services (CMS); or have been certified by a credentialing body for the care of bariatric clients. Facilities complying with CMS criteria may be found by searching the [Medicare Approved Facilities for Bariatric Surgery](#).
2. Pre- and post- operative care/evaluations:
 - 2.1. Office;
 - 2.2. Clinic.

Eligible Clients

1. All currently enrolled Medicaid clients over the age of 16 are eligible for this service.
2. Clients enrolled in the Primary Care Physician Program (PCPP) and the Accountable Care Collaborative (ACC) must obtain a referral to a specialist for services to be reimbursed.

Covered Services and Limitations

Colorado Medicaid will reimburse participating providers for no more than one bariatric procedure per client lifetime, unless a revision is appropriate based on one of the complications identified below.

PRIMARY PROCEDURES INCLUDE:

1. Roux-en-Y Gastric Bypass;
2. Adjustable Gastric Banding;
3. Biliopancreatic Diversion with or without Duodenal Switch;
4. Vertical-Banded Gastroplasty;
5. Vertical Sleeve Gastroplasty.

REVISION OF SURGERY FOR CLINICALLY SEVERE OBESITY:

Revision of a surgery for clinically severe obesity is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, stricture following one of the above procedures, and other conditions (see below).

CRITERIA FOR PRIMARY PROCEDURE

All of the first **four** criteria listed below must be met in order to authorize bariatric surgery. The **fifth** criterion applies to clients under the age of 18. Clients not meeting the criteria, who have



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one or more immediate, life-threatening co-morbidities, will be considered for approval on a case-by-case basis.

1. The client is clinically obese with one of the following:
 - 1.1. BMI of 40 or higher, **or**
 - 1.2. BMI of 35-40 with objective measurements documenting one of more of the following co-morbid conditions:
 - 1.2.1. Severe cardiac disease (coronary artery disease, pulmonary hypertension, congestive heart failure, or cardiomyopathy);
 - 1.2.2. Type 2 diabetes mellitus;
 - 1.2.3. Obstructive sleep apnea or other respiratory disease (chronic asthma, obesity hypoventilation syndrome, or Pickwickian syndrome);
 - 1.2.4. Pseudo-tumor cerebri;
 - 1.2.5. Hypertension;
 - 1.2.6. Hyperlipidemia;
 - 1.2.7. Severe joint or disc disease that interferes with daily functioning;
 - 1.2.8. Intertriginous soft-tissue infections, nonalcoholic steatohepatitis, stress urinary incontinence, recurrent or persistent venous stasis disease, or significant impairment in Activities of Daily Living (ADL).
2. The BMI level qualifying the client for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A client's required attempts to lose weight may cause their BMI to fluctuate around the discrete required levels during the two-year period. The two-year period will not necessarily start over, or be prolonged, under this scenario, but will be decided on a case-by-case basis.
3. The client must have made at least one serious clinically supervised attempt to lose weight (6 months or longer) within the past 18 months of the prior authorization request, under the supervision of a registered dietician working in consultation with a physician, nurse practitioner, or physician's assistant.
4. Medical and psychiatric contraindications to the surgical procedure have been ruled out through:
 - 4.1. A complete history and physical conducted by or in consultation with the requesting surgeon; and
 - 4.2. A psychiatric or psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The



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assessment must address both potential psychiatric contraindications and client's ability to comply with the long-term postoperative care plan.

4.3. The client must:

- 4.3.1. Be motivated and committed to losing weight;
- 4.3.2. Have realistic expectations of the surgical outcome;
- 4.3.3. Postoperatively be willing to make permanent lifestyle changes in the areas of:
 - 4.3.3.1. Eating behaviors;
 - 4.3.3.2. Other behaviors contributing to obesity; and
 - 4.3.3.3. Exercise therapy;
- 4.3.4. Be willing to participate in the long-term postoperative care plan offered by the surgery program, consisting of:
 - 4.3.4.1. Education and support;
 - 4.3.4.2. Diet therapy;
 - 4.3.4.3. Behavior modification; and
 - 4.3.4.4. Activity/exercise components.

5. For clients under the age of 18, the following must be documented:

- 5.1. The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome;
- 5.2. Girls have attained Tanner stage IV breast development; and
- 5.3. Bone age studies estimate the attainment of 95% of projected adult height.

CRITERIA FOR REVISION PROCEDURES

Indications for surgical revision include, but may not be limited to:

- 1. Weight loss to 20% below the ideal body weight;
- 2. Esophagitis, unresponsive to nonsurgical treatment;
- 3. Hemorrhage or hematoma complicating a procedure;
- 4. Excessive bilious vomiting following gastrointestinal surgery;
- 5. Complications of the intestinal anastomosis and bypass;
- 6. Stomal dilation, documented by endoscopy;
- 7. Documented slippage of the adjustable gastric band;
- 8. Pouch dilation documented by upper gastrointestinal examination or endoscopy producing weight gain of 20% or more, provided that:
 - 8.1. The primary procedure was successful in inducing weight loss prior to the pouch dilation; and
 - 8.2. The client has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at



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current time must be submitted along with surgeon's statement to document compliance with diet and exercise); and

9. Other and unspecified post-surgical non-absorption (such as hypoglycemia and malnutrition following gastrointestinal surgery).

Requirements

PRIOR AUTHORIZATION REQUIREMENTS

All bariatric surgical procedures require prior authorization.

WRITTEN DOCUMENTATION:

1. Height, weight, BMI with duration.
2. Co-morbid conditions – list and describe each, with attention to any contraindication which might affect the surgery. Include all objective measurements.
3. Detailed account of the client's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician (physician, registered dietitian, nurse practitioner, or physician assistant), and evidence of successful completion and compliance.
4. A copy of the current psychiatric or psychological assessment as described above. Include a statement about presence or absence of contraindication to surgery based on client's mental health assessment.
5. A statement written or agreed to by the client detailing for the interdisciplinary team the client's:
 - 5.1. Commitment to lose weight;
 - 5.2. Expectations of the surgical outcome;
 - 5.3. Willingness to make permanent life-style changes; and
 - 5.4. If female, client's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within 2 years of surgery.
 - 5.4.1. Anticipatory Guidance: The client must be informed that should she choose to breastfeed following her bariatric procedure, she will need closer monitoring for her and her child because her nutritional aspects may have changed.
6. A description of the post-surgical follow-up program.
7. For clients under the age of 18, include a statement verifying the attainment of physiologic maturity, as defined above.



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DOCUMENTATION FOR REVISION OF BARIATRIC SURGERY

1. Initial height and weight.
2. Initial surgery – type, date.
3. Weight loss history after the surgery.
4. Present weight.
5. Dietary assessment by registered dietician regarding current eating habits.
6. X-ray or endoscopic report that demonstrates the staple line has failed, the pouch has enlarged, or one of the above-listed conditions is present.
7. Copy of the psychiatric or psychological opinion ruling out psychiatric contraindications to the procedure. If the client is currently receiving psychiatric treatment, a current diagnostic assessment must be submitted.

Non-Covered Services

Bariatric Surgery is **not** covered for the following instances:

1. For clients with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema;
2. Repeat procedures not associated with surgical complications;
3. Cosmetic Follow-up: Weight loss following surgery for clinically severe obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit; or
4. During pregnancy.

References

Aetna Insurance Company. Clinical Policy Bulletins. Obesity Surgery. 2005; No. 0157:1-22.

American College of Surgeons. Committee on Emerging Surgical Technology and Education. [ST-34]. Recommendations for facilities performing bariatric surgery. *Bulletin of the American College of Surgeons*. 2000; 85: Available at: http://www.facs.org/fellows_info/statements/st-34.html. Accessed April 5, 2010.

Blackburn G, Hu F, Harvey A, et al. Expert panel on weight loss surgery. Betsy Lehman Center for Patient Safety and Medical Error Reduction. Evidence-based recommendations for best practices in weight loss surgery. *Obesity Research*. 2005; 13: 203-305.



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Blue Cross Blue Shield Association Technology Assessment Program. Newer techniques in bariatric surgery for morbid obesity: laparoscopic adjustable gastric banding, biliopancreatic diversion and long-limb gastric bypass. 2005; 20(5):1-72.

Brechner R, Farris C, Harrison, Tillman, K, Salive C, Phurrough S. Summary of Evidence – Bariatric Surgery. November 2004. CMS Report. Available at: <http://www.cms.hhs.gov/FACA/downloads/id26c.pdf> Accessed April 5, 2010.

Buchwald H, Avidor Y, Braunwald E, et al. Bariatric Surgery: A Systematic Review and Meta-Analysis. *JAMA*. 2004; 292:1724-1737.

Chevallier JM, Zinzindohoue F, Douard R, et al. Complications after laparoscopic adjustable gastric banding for morbid obesity: experience with 1,000 patients over 7 years. *Obes Surg*. 2004;14:407-414.

Finkelstein EA, Brown DS A cost-benefit simulation model of coverage for bariatric surgery among full-time employees. *AJ Managed Care* Oct 2005;11(10):641-6

Gallagher SF, Banasiak M, Gonzalvo JP, et al. The impact of bariatric surgery on the Veterans Administration healthcare system: a cost analysis. *Obes. Surg*. 2003;13:245-248
Gastrointestinal Surgery for Severe Obesity. NIH Consensus Statement Online 1991 Mar 25-27. 9(1):1-20. Accessed September 2, 2005.

Inge T, Krebs N, Garcia V, et al. Bariatric surgery for severely overweight adolescents: concerns and recommendations. *Pediatrics*. 2004;114:217-223.

Lee WJ, Huang MT, Yu PJ, Wang W, Chen TC. Laparoscopic vertical banded gastroplasty and laparoscopic gastric bypass: a comparison. *Obes Surg*. 2004;14:626-634.

Manterola C, Pineda V, Vial M, Losada H, Munos S. Surgery for Morbid Obesity: Selection of Operation Based on Evidence from Literature Review. *Obes Surg*. 2005; 15:106-113.

Mason E. Gastric Surgery for morbid obesity. *Surg Clin N America*. 1992;72:501-513.

Mognol P, Chosidow D, Marmuse JP. Laparoscopic gastric bypass versus laparoscopic adjustable gastric banding in the superobese: a comparative study of 290 patients. *Obes Surg*. 2005;15:76-81.

NIH. E.Xavier Pi-Sunyer, Chair of Expert Panel “Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. The Evidence Report.” National Institute of Health Publication No. 98-4083. September, 1998.

Puzziferri N, Austreheim IT, Wolfe BM, et al. Three-year follow-up of a prospective randomized trial comparing laparoscopic versus open gastric bypass. *Ann Surg*. Feb 2006;243(2):181-188



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Sjostrom L, Lindroos A, Peltonen M, et al. Lifestyle, Diabetes, and Cardiovascular Risk Factors 10 Years after Bariatric Surgery. *New Engl J Med*. 2004;351:2683-2693.

Snow V, Barry P, Fitterman N, Qaseem A, Weiss K, for the clinical Efficacy Assessment Subcommittee of the American College of Physicians. Pharmacologic and surgical management of obesity in primary care: a clinical practice guideline from the American College of Physicians. *Ann Intern Med*. 2005;142:525-531.

Society of American Gastrointestinal Endoscopic Surgeons (SAGES). Guidelines for the clinical application of laparoscopic bariatric surgery. 2003;Publication 0030; 1-6. Available at: <http://www.sages.org/sagespublication.php?doc=30>. Accessed April 5, 2010.

Sogg S, Mori DAL. The Boston interview for gastric bypass: determining the psychological suitability of surgical candidates. *Obes Surg*. 2004;14:370-380.

Watkins BM, Montgomery KF, Ahronie JH. Laparoscopic adjustable gastric banding: early experience in 400 consecutive patients in the USA. *Obes Surg*. 2005;15:82-87.

Weber M, Muller M, Bucher T, et al. Laparoscopic gastric bypass is superior to laparoscopic gastric banding for treatment of morbid obesity. *Ann Surg*. 2004; 240:975-983.

Zingmond, DS,, McGory ML, and Ko CY, Hospitalization before and after gastric bypass surgery. *JAMA*; October 2005;294(15):1918-1924



Medicaid Director Signature



Date